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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.akforest.org or by calling 1-907-225-6114.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 individual / $4,000 family. Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your deductible starts over January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**
Are there other deductibles for specific services?	**No**	
Is there an out–of–pocket limit on my expenses?	$6,350 individual / $12,700 family	The **out of pocket limit** is the most you could pay during the coverage period –Jan 1 through Dec 31, for your share of the cost of covered services. This limit helps you plan for health care expenses
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out of pocket limit**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	No	This plan treats **providers** the same in determining payment for the same services
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	None
	Specialist visit	20% coinsurance	None
	Other practitioner office visit	20% coinsurance	Spinal manipulations limited to 10 visits per calendar year
	Preventive care/screening/immunization	No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.akforest.org.	Generic drugs	20% coinsurance	Covers up to a 90 day supply
	Preferred brand drugs	40% coinsurance	Covers up to a 90 day supply
	Specialty drugs	40% coinsurance	Covers up to a 90 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	None

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	
	Emergency medical transportation	20% coinsurance	None
	Emergency Airlift transportation	20% coinsurance	Upon arrival at the treating facility, the patient must remain a registered bed patient for at least 24 hours. Benefits are limited to one Airlift every 12 month.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Authorization is required for all inpatient admissions. An additional $200 copay will apply for unauthorized admissions
	Physician/surgeon fee	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	None
	Mental/Behavioral health inpatient services	20% coinsurance	Authorization is required for all inpatient admissions. An additional $200 copay will apply for unauthorized admissions
	Substance use disorder outpatient services	20% coinsurance	None
	Substance use disorder inpatient services	20% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	None
	Delivery and all inpatient services	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Limited to 60 visits per calendar year
	Rehabilitation services	20% coinsurance	None
	Habilitation services	20% coinsurance	None
	Skilled nursing care	20% coinsurance	None
	Durable medical equipment	20% coinsurance	None
	Hospice service	20% coinsurance	Lifetime maximum is 6 months of care
If your child needs dental or eye care	Eye exam	10% coinsurance	One eye exam every 12 months
	Glasses	No coinsurance	One set of lenses every 12 months. One frame every 24 months
	Dental check-up	20% coinsurance	Limited to one check-up every 6 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic Surgery
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside of the US
- Private-duty nursing
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Dental Care
- Hearing Aids
- Adult Routine eye care
- Adult Routine foot care

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if: You commit fraud, the insurer stops offering services in the State or you move outside the coverage area.
Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if: You commit fraud, the insurer stops offering services in the State or you move outside the coverage area.
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continuation coverage may also apply. For more information on your rights to continue coverage, contact Tongass Timber Trust at 907-225-6114. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Tongass Timber Trust at 907-225-6114. You can the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For questions about your rights, this notice, or assistance, you can contact the State of Alaska Insurance Department at 907-279-7900. Additionally, a consumer assistance program can help you file your appeal. Contact 907-279-7900.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,432
- **Patient pays** $3,108

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions Generic	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$
Coinsurance	$1,108
Limits or exclusions	$
Total	**$3,108**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

Sample care costs:

Prescriptions Generic	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$
Coinsurance	$680
Limits or exclusions	$
Total	**$2,680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.